

div. C, title II, §§211(c), 212(b)(1)–(2)(B), Dec. 20, 2006, 120 Stat. 3023, 3025, 3026.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(3)(C), (D), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Title XVIII of the Act is classified generally to subchapter XVIII (§1395 et seq.) of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

AMENDMENTS

2006—Subsec. (a)(3), (4). Pub. L. 109–432, §212(b)(1), added pars. (3) and (4).

Subsec. (d)(1). Pub. L. 109–432, §212(b)(2)(A), amended text of par. (1) generally. Prior to amendment, par. (1) provided that the contribution requirements of all 1988 last signatory operators include the payment of an annual prefunding premium for all eligible and potentially eligible beneficiaries, payment of a monthly per beneficiary premium, and provision of security.

Subsec. (d)(2)(B). Pub. L. 109–432, §212(b)(2)(B)(i), substituted “backstop” for “prefunding”.

Subsec. (d)(3). Pub. L. 109–432, §212(b)(2)(B)(ii), substituted “paragraph (1)(A)” for “paragraph (1)(B)”.

Subsec. (d)(4). Pub. L. 109–432, §211(c), inserted at end “The provisions of section 9711(c)(2) shall apply to any last signatory operator described in such section (without regard to whether security is provided under such section, a payment is made under section 9704(j), or both) and if security meeting the requirements of section 9711(c)(3) is provided, the common parent described in section 9711(c)(2)(B) shall be exclusively responsible for any liability for premiums under this section which, but for this sentence, would be required to be paid by the last signatory operator or any related person.”

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. C, title II, §212(b)(2)(C), Dec. 20, 2006, 120 Stat. 3026, provided that: “The amendments made by this paragraph [amending this section] shall apply to fiscal years beginning on or after October 1, 2010.”

Subchapter D—Other Provisions

Sec.	
9721.	Civil enforcement.
9722.	Sham transactions.

§ 9721. Civil enforcement

The provisions of section 4301 of the Employee Retirement Income Security Act of 1974 shall apply, in the same manner as any claim arising out of an obligation to pay withdrawal liability under subtitle E of title IV of such Act, to any claim—

- (1) arising out of an obligation to pay any amount required to be paid by this chapter; or
- (2) arising out of an obligation to pay any amount required by section 402(h)(5)(B)(ii) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1232(h)(5)(B)(ii)).

(Added Pub. L. 102–486, title XIX, §19143(a), Oct. 24, 1992, 106 Stat. 3055; amended Pub. L. 109–432, div. C, title II, §213(b)(2), Dec. 20, 2006, 120 Stat. 3027.)

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in text, is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829, as amended. Subtitle E of title IV of the Act is classified generally to subtitle E (§1381 et seq.) of subchapter III of chapter 18 of Title 29, Labor. Section 4301 of the Act is classified to section 1451 of Title

29. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

AMENDMENTS

2006—Pub. L. 109–432 reenacted section catchline without change and amended text generally. Prior to amendment, text read as follows: “The provisions of section 4301 of the Employee Retirement Income Security Act of 1974 shall apply to any claim arising out of an obligation to pay any amount required to be paid by this chapter in the same manner as any claim arising out of an obligation to pay withdrawal liability under subtitle E of title IV of such Act. For purposes of the preceding sentence, a signatory operator and related persons shall be treated in the same manner as employers.”

§ 9722. Sham transactions

If a principal purpose of any transaction is to evade or avoid liability under this chapter, this chapter shall be applied (and such liability shall be imposed) without regard to such transaction.

(Added Pub. L. 102–486, title XIX, §19143(a), Oct. 24, 1992, 106 Stat. 3056.)

Subtitle K—Group Health Plan Requirements

Chapter		Sec. ¹
100.	Group health plan requirements	9801

AMENDMENTS

1997—Pub. L. 105–34, title XV, §1531(a)(1), Aug. 5, 1997, 111 Stat. 1080, struck out “Portability, Access, and Renewability” before “Requirements” in subtitle heading and made similar change in item for chapter 100.

CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

Subchapter		Sec. ¹
A.	Requirements relating to portability, access, and renewability	9801
B.	Other requirements	9811
C.	General provisions	9831

AMENDMENTS

1997—Pub. L. 105–34, title XV, §1531(a)(1), Aug. 5, 1997, 111 Stat. 1080, struck out “PORTABILITY, ACCESS, AND RENEWABILITY” in chapter heading and added analysis for chapter.

Subchapter A—Requirements Relating to Portability, Access, and Renewability

Sec.	
9801.	Increased portability through limitation on preexisting condition exclusions.
9802.	Prohibiting discrimination against individual participants and beneficiaries based on health status.
9803.	Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements.
[9804–9806. Renumbered.]	

AMENDMENTS

1997—Pub. L. 105–34, title XV, §1531(a)(1), Aug. 5, 1997, 111 Stat. 1081, added subchapter heading and items 9801 to 9803 and struck out former items 9801 “Increased portability through limitation on preexisting condition exclusions”, 9802 “Prohibiting discrimination against

¹ Section number editorially supplied.

¹ Section numbers editorially supplied.

individual participants and beneficiaries based on health status”, 9803 “Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements”, 9804 “General exceptions”, 9805 “Definitions”, and 9806 “Regulations”.

§ 9801. Increased portability through limitation on preexisting condition exclusions

(a) Limitation on preexisting condition exclusion period; crediting for periods of previous coverage

Subject to subsection (d), a group health plan may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

- (1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;
- (2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and
- (3) the period of any such preexisting condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions

For purposes of this section—

(1) Preexisting condition exclusion

(A) In general

The term “preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

For purposes of this section, genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term “enrollment date” means, with respect to an individual covered under a group health plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term “late enrollee” means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

- (A) the first period in which the individual is eligible to enroll under the plan, or
- (B) a special enrollment period under subsection (f).

(4) Waiting period

The term “waiting period” means, with respect to a group health plan and an individual

who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) Creditable coverage defined

For purposes of this part, the term “creditable coverage” means, with respect to an individual, coverage of the individual under any of the following:

- (A) A group health plan.
- (B) Health insurance coverage.
- (C) Part A or part B of title XVIII of the Social Security Act.
- (D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
- (E) Chapter 55 of title 10, United States Code.
- (F) A medical care program of the Indian Health Service or of a tribal organization.
- (G) A State health benefits risk pool.
- (H) A health plan offered under chapter 89 of title 5, United States Code.
- (I) A public health plan (as defined in regulations).
- (J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 9832(c)).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under subparagraph (A).

(C) Affiliation period

(i) In general

For purposes of this section, the term “affiliation period” means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. During such an affiliation period, the organization is not required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(ii) Beginning

Such period shall begin on the enrollment date.

(iii) Runs concurrently with waiting periods

Any such affiliation period shall run concurrently with any waiting period under the plan.

(D) TAA-eligible individuals

In the case of plan years beginning before January 1, 2014—

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date which is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions

The terms “TAA-eligible individual” and “TAA-related loss of coverage” have the meanings given such terms in section 4980B(f)(5)(C)(iv).

(3) Method of crediting coverage**(A) Standard method**

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan shall count a period of creditable coverage without regard to the specific benefits for which coverage is offered during the period.

(B) Election of alternative method

A group health plan may elect to apply subsection (a)(3) based on coverage of any benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B), the plan shall—

- (i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and
- (ii) include in such statements a description of the effect of this election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

(d) Exceptions**(1) Exclusion not applicable to certain new-borns**

Subject to paragraph (4), a group health plan may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children

Subject to paragraph (4), a group health plan may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy

For purposes of this section, a group health plan may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage**(1) Requirement for certification of period of creditable coverage****(A) In general**

A group health plan shall provide the certification described in subparagraph (B)—

- (i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,
- (ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and
- (iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of—

- (i) the period of creditable coverage of the individual under such plan and the coverage under such COBRA continuation provision, and
- (ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of health insurance coverage offered in connection with the plan, the plan is deemed to have satisfied the certification requirement under this paragraph if the issuer provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits**(A) In general**

In the case of an election described in subsection (c)(3)(B) by a group health plan, if the plan enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(i) upon request of such plan, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan information on coverage of classes and categories of health benefits available under such entity's plan, and

(ii) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods**(1) Individuals losing other coverage**

A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor (or the health insurance issuer offering health insurance coverage in connection with the plan) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a

result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries**(A) In general**

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

The dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks coverage of a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules relating to Medicaid and CHIP**(A) In general**

A group health plan shall permit an employee who is eligible, but not enrolled, for

coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage

The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan not later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP

The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Employee outreach and disclosure

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage

(I) In general

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this clause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

(II) Option to provide concurrent with provision of plan materials to employee

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season

or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024).

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2073; amended Pub. L. 105-34, title XV, § 1531(b)(1)(A), Aug. 5, 1997, 111 Stat. 1084; Pub. L. 111-3, title III, § 311(a), Feb. 4, 2009, 123 Stat. 64; Pub. L. 111-5, div. B, title I, § 1899D(a), Feb. 17, 2009, 123 Stat. 425; Pub. L. 111-344, title I, § 114(a), Dec. 29, 2010, 124 Stat. 3615; Pub. L. 112-40, title II, § 242(a)(1), Oct. 21, 2011, 125 Stat. 419.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (c)(1)(C), (D), (f)(3)(A)(i), (B)(1)(I), (ii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Parts A and B of title XVIII of the Act are classified generally to parts A (§ 1395c et seq.) and B (§ 1395j et seq.) of subchapter XVIII of chapter 7 of Title 42, The Public Health and Welfare. Titles XIX and XXI of the Act are classified generally to subchapters XIX (§ 1396 et seq.) and XXI (§ 1397aa et seq.), respectively, of chapter 7 of Title 42. Sections 1928 and 2105 of the Act are classified to sections 1396s and 1397ee, respectively, of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, referred to in subsec. (f)(3)(B)(ii), is section 311(b)(1)(C) of Pub. L. 111-3, which is set out as a note under section 1181 of Title 29, Labor.

AMENDMENTS

2011—Subsec. (c)(2)(D). Pub. L. 112-40 substituted “January 1, 2014” for “February 13, 2011” in introductory provisions.

2010—Subsec. (c)(2)(D). Pub. L. 111-344 substituted “February 13, 2011” for “January 1, 2011” in introductory provisions.

2009—Subsec. (c)(2)(D). Pub. L. 111-5 added subpar. (D).

Subsec. (f)(3). Pub. L. 111-3 added par. (3).

1997—Subsec. (c)(1). Pub. L. 105-34 substituted “section 9832(c)” for “section 9805(c)” in concluding provisions.

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112-40, title II, §242(b), Oct. 21, 2011, 125 Stat. 419, provided that:

“(1) IN GENERAL.—The amendments made by this section [amending this section, section 1181 of Title 29, Labor, and sections 300gg and 300gg-3 of Title 42, The Public Health and Welfare] shall apply to plan years beginning after February 12, 2011.

“(2) TRANSITIONAL RULES.—

“(A) BENEFIT DETERMINATIONS.—Notwithstanding the amendments made by this section (and the provisions of law amended thereby), a plan shall not be required to modify benefit determinations for the period beginning on February 13, 2011, and ending 30 days after the date of the enactment of this Act [Oct. 21, 2011], but a plan shall not fail to be qualified health insurance within the meaning of section 35(e) of the Internal Revenue Code of 1986 during this period merely due to such failure to modify benefit determinations.

“(B) GUIDANCE CONCERNING PERIODS BEFORE 30 DAYS AFTER ENACTMENT.—Except as provided in subparagraph (A), the Secretary of the Treasury (or his designee), in consultation with the Secretary of Health and Human Services and the Secretary of Labor, may issue regulations or other guidance regarding the scope of the application of the amendments made by this section to periods before the date which is 30 days after the date of the enactment of this Act.

“(C) SPECIAL RULE RELATING TO CERTAIN LOSS OF COVERAGE.—In the case of a TAA-related loss of coverage (as defined in section 4980B(f)(5)(C)(iv) of the Internal Revenue Code of 1986) that occurs during the period beginning on February 13, 2011, and ending 30 days after the date of the enactment of this Act, the 7-day period described in section 9801(c)(2)(D) of the Internal Revenue Code of 1986, section 701(c)(2)(C) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181(c)(2)(C)], and section 2701(c)(2)(C) of the Public Health Service Act [renumbered section 2704(c)(2)(C), see 42 U.S.C. 300gg-3(c)(2)(C)] shall be extended until 30 days after such date of enactment.”

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-344, title I, §114(d), Dec. 29, 2010, 124 Stat. 3615, provided that: “The amendments made by this section [amending this section, section 1181 of Title 29, Labor, and section 300gg of Title 42, The Public Health and Welfare] shall apply to plan years beginning after December 31, 2010.”

EFFECTIVE DATE OF 2009 AMENDMENT

Except as otherwise provided and subject to certain applicability provisions, amendment by Pub. L. 111-5 effective upon the expiration of the 90-day period beginning on Feb. 17, 2009, see section 1891 of Pub. L. 111-5, set out as an Effective and Termination Dates of 2009 Amendment note under section 2271 of Title 19, Customs Duties.

Pub. L. 111-5, div. B, title I, §1899D(d), Feb. 17, 2009, 123 Stat. 426, provided that: “The amendments made by this section [amending this section, section 1181 of Title 29, Labor, and section 300gg of Title 42, The Public Health and Welfare] shall apply to plan years beginning after the date of the enactment of this Act [Feb. 17, 2009].”

Amendment by Pub. L. 111-3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111-3, set out as an Effective Date note under section 1396 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105-34 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 1531(c) of Pub. L. 105-34, set out as a note under section 4980D of this title.

EFFECTIVE DATE

Pub. L. 104-191, title IV, §401(c), Aug. 21, 1996, 110 Stat. 2082, provided that:

“(1) IN GENERAL.—The amendments made by this section [enacting this subtitle] shall apply to plan years beginning after June 30, 1997.

“(2) DETERMINATION OF CREDITABLE COVERAGE.—

“(A) PERIOD OF COVERAGE.—

“(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under chapter 100 of the Internal Revenue Code of 1986 (as added by this section) in determining creditable coverage.

“(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of the Treasury, consistent with section 104 [42 U.S.C. 300gg-92 note], shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

“(B) CERTIFICATIONS, ETC.—

“(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 9801 of the Internal Revenue Code of 1986 (as added by this section) shall apply to events occurring after June 30, 1996.

“(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

“(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

“(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

“(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

“(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

“(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Aug. 21, 1996], the amendments made by this section shall not apply to plan years beginning before the later of—

“(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

“(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

“(4) **TIMELY REGULATIONS.**—The Secretary of the Treasury, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

“(5) **LIMITATION ON ACTIONS.**—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.”

§ 9802. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In eligibility to enroll

(1) In general

Subject to paragraph (2), a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following factors in relation to the individual or a dependent of the individual:

- (A) Health status.
- (B) Medical condition (including both physical and mental illnesses).
- (C) Claims experience.
- (D) Receipt of health care.
- (E) Medical history.
- (F) Genetic information.
- (G) Evidence of insurability (including conditions arising out of acts of domestic violence).
- (H) Disability.

(2) No application to benefits or exclusions

To the extent consistent with section 9801, paragraph (1) shall not be construed—

- (A) to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such plan; or
- (B) to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) Construction

For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions

(1) In general

A group health plan may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any factor described in subsection (a)(1) in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) Genetic testing

(1) Limitation on requesting or requiring genetic testing

A group health plan may not request or require an individual or a family member of such individual to undergo a genetic test.

(2) Rule of construction

Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) Rule of construction regarding payment

(A) In general

Nothing in paragraph (1) shall be construed to preclude a group health plan from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary of Health and Human Services under part C of title XI of the Social Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

(B) Limitation

For purposes of subparagraph (A), a group health plan may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception

Notwithstanding paragraph (1), a group health plan may request, but not require, that

a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan notifies the Secretary in writing that the plan is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) Prohibition on collection of genetic information

(1) In general

A group health plan shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 9832).

(2) Prohibition on collection of genetic information prior to enrollment

A group health plan shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or in connection with such enrollment.

(3) Incidental collection

If a group health plan obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) Application to all plans

The provisions of subsections (a)(1)(F), (b)(3), (c), and (d) and subsection (b)(1) and section 9801 with respect to genetic information, shall apply to group health plans without regard to section 9831(a)(2).

(f) Special rules for church plans

A church plan (as defined in section 414(e)) shall not be treated as failing to meet the requirements of this section solely because such plan requires evidence of good health for coverage of—

(1) both any employee of an employer with 10 or less employees (determined without regard to section 414(e)(3)(C)) and any self-employed individual, or

(2) any individual who enrolls after the first 90 days of initial eligibility under the plan.

This subsection shall apply to a plan for any year only if the plan included the provisions described in the preceding sentence on July 15, 1997, and at all times thereafter before the beginning of such year.

(g) Genetic information of a fetus or embryo

Any reference in this chapter to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2078; amended Pub. L. 105-34, title XV, § 1532(a), Aug. 5, 1997, 111 Stat. 1085; Pub. L. 110-233, title I, § 103(a)-(c), May 21, 2008, 122 Stat. 896, 897; Pub. L. 113-295, div. A, title II, § 220(aa), Dec. 19, 2014, 128 Stat. 4037.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(3)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part C of title XI of the Act is classified generally to part C (§ 1320d et seq.) of subchapter XI of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c)(3)(A), is section 264 of Pub. L. 104-191, which is set out as a note under section 1320d-2 of Title 42, The Public Health and Welfare.

AMENDMENTS

2014—Subsecs. (f), (g). Pub. L. 113-295 redesignated subsec. (f) relating to genetic information of a fetus or embryo as (g).

2008—Subsec. (b)(2)(A). Pub. L. 110-233, § 103(a)(1), inserted “except as provided in paragraph (3)” before semicolon.

Subsec. (b)(3). Pub. L. 110-233, § 103(a)(2), added par. (3).

Subsecs. (c) to (e). Pub. L. 110-233, § 103(b), added subsecs. (c) to (e). Former subsec. (c) redesignated (f) relating to special rules for church plans.

Subsec. (f). Pub. L. 110-233, § 103(c), added subsec. (f) relating to genetic information of a fetus or embryo.

Pub. L. 110-233, § 103(b), redesignated subsec. (c) as (f) relating to special rules for church plans.

1997—Subsec. (c). Pub. L. 105-34 added subsec. (c).

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110-233, title I, § 103(f)(2), May 21, 2008, 122 Stat. 899, provided that: “The amendments made by this section [enacting section 9834 of this title and amending this section and section 9832 of this title] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of the enactment of this Act [May 21, 2008].”

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105-34, title XV, § 1532(b), Aug. 5, 1997, 111 Stat. 1085, provided that: “The amendments made by subsection (a) [amending this section] shall take effect as if included in the amendments made by section 401(a) of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191].”

REGULATIONS

Pub. L. 110-233, title I, §103(f)(1), May 21, 2008, 122 Stat. 899, provided that: “The Secretary of the Treasury shall issue final regulations or other guidance not later than 12 months after the date of the enactment of this Act [May 21, 2008] to carry out the amendments made by this section [enacting section 9834 of this title and amending this section and section 9832 of this title].”

§ 9803. Guaranteed renewability in multi-employer plans and certain multiple employer welfare arrangements

(a) In general

A group health plan which is a multiemployer plan (as defined in section 414(f)) or which is a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under such plan, other than—

- (1) for nonpayment of contributions;
- (2) for fraud or other intentional misrepresentation of material fact by the employer;
- (3) for noncompliance with material plan provisions;
- (4) because the plan is ceasing to offer any coverage in a geographic area;
- (5) in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or a factor described in section 9802(a)(1) in relation to such individuals or their dependents; or
- (6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

(b) Multiple employer welfare arrangement

For purposes of subsection (a), the term “multiple employer welfare arrangement” has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section.

(Added Pub. L. 104-191, title IV, §401(a), Aug. 21, 1996, 110 Stat. 2079.)

REFERENCES IN TEXT

Section 3(40) of the Employee Retirement Income Security Act of 1974, referred to in subsec. (b), is classified to section 1002(40) of Title 29, Labor.

The date of the enactment of this section, referred to in subsec. (b), is the date of enactment of Pub. L. 104-191, which was approved Aug. 21, 1996.

[§ 9804. Renumbered § 9831]

[§ 9805. Renumbered § 9832]

[§ 9806. Renumbered § 9833]

Subchapter B—Other Requirements

Sec.
9811. Standards relating to benefits for mothers and newborns.

Sec.
9812. Parity in mental health and substance use disorder benefits.
9813. Coverage of dependent students on medically necessary leave of absence.
9815. Additional market reforms.¹

AMENDMENTS

2008—Pub. L. 110-381, §2(c)(2), Oct. 9, 2008, 122 Stat. 4086, added item 9813.

Pub. L. 110-343, div. C, title V, §512(g)(3)(B), Oct. 3, 2008, 122 Stat. 3892, added item 9812 and struck out former item 9812 “Parity in the application of certain limits to mental health benefits”.

1997—Pub. L. 105-34, title XV, §1531(a)(4), Aug. 5, 1997, 111 Stat. 1081, added subchapter heading and analysis.

§ 9811. Standards relating to benefits for mothers and newborns

(a) Requirements for minimum hospital stay following birth

(1) In general

A group health plan may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a caesarean section, to less than 96 hours; or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) Exception

Paragraph (1)(A) shall not apply in connection with any group health plan in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

(b) Prohibitions

A group health plan may not—

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such

¹Editorially supplied. Section 9815 added by Pub. L. 111-148 without corresponding amendment of analysis. No section 9814 has been enacted.

provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) Rules of construction

(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

(A) to give birth in a hospital; or

(B) to stay in the hospital for a fixed period of time following the birth of her child.

(2) This section shall not apply with respect to any group health plan which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this section shall be construed as preventing a group health plan from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan, except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) Level and type of reimbursements

Nothing in this section shall be construed to prevent a group health plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(e) Preemption; exception for health insurance coverage in certain States

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (including a decision, rule, regulation, or other State action having the effect of law) for a State that regulates such coverage that is described in any of the following paragraphs:

(1) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a caesarean section.

(2) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(3) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(Added Pub. L. 105-34, title XV, § 1531(a)(4), Aug. 5, 1997, 111 Stat. 1081; amended Pub. L. 105-206, title VI, § 6015(e), July 22, 1998, 112 Stat. 821.)

AMENDMENTS

1998—Subsecs. (e), (f). Pub. L. 105-206 redesignated subsec. (f) as (e).

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by Pub. L. 105-206 effective, except as otherwise provided, as if included in the provisions of the Taxpayer Relief Act of 1997, Pub. L. 105-34, to which such amendment relates, see section 6024 of Pub. L. 105-206, set out as a note under section 1 of this title.

EFFECTIVE DATE

Subchapter applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 1531(c) of Pub. L. 105-34, set out as an Effective Date of 1997 Amendment note under section 4980D of this title.

§ 9812. Parity in mental health and substance use disorder benefits

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No lifetime limit

If the plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit

If the plan includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable lifetime limit”), the plan shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits

In the case of a plan that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits

In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No annual limit

If the plan does not include an annual limit on substantially all medical and surgical benefits, the plan may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit

If the plan includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable annual limit”), the plan shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits

In the case of a plan that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations**(A) In general**

In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan, and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

The term “financial requirement” includes deductibles, copayments, coinsur-

ance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),¹

(ii) Predominant

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation

The term “treatment limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits shall be made available by the plan administrator in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers

In the case of a plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan provides coverage for medical or surgical benefits provided by out-of-network providers, the plan shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(b) Construction

Nothing in this section shall be construed—

(1) as requiring a group health plan to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan relating to such benefits under the plan, except as provided in subsection (a).

(c) Exemptions**(1) Small employer exemption****(A) In general**

This section shall not apply to any group health plan for any plan year of a small employer.

(B) Small employer

For purposes of subparagraph (A), the term “small employer” means, with respect to a calendar year and a plan year, an employer who employed an average of at least 2 (or 1

¹ So in original. The comma probably should be a period.

in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer and rules similar to rules of subparagraphs (B) and (C) of section 4980D(d)(2) shall apply.

(2) Cost exemption

(A) In general

With respect to a group health plan, if the application of this section to such plan results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan during the following plan year, and such exemption shall apply to the plan for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan involved regardless of any increase in total costs.

(B) Applicable percentage

With respect to a plan, the applicable percentage described in this subparagraph shall be—

- (i) 2 percent in the case of the first plan year in which this section is applied; and
- (ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries

Determinations as to increases in actual costs under a plan for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations

If a group health plan seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan has complied with this section for the first 6 months of the plan year involved.

(E) Notification

(i) In general

A group health plan that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and

participants and beneficiaries in the plan of such election.

(ii) Requirement

A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan;

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality

A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies

To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) Separate application to each option offered

In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions

For purposes of this section:

(1) Aggregate lifetime limit

The term “aggregate lifetime limit” means, with respect to benefits under a group health plan, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan with respect to an individual or other coverage unit.

(2) Annual limit

The term “annual limit” means, with respect to benefits under a group health plan, a

dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan with respect to an individual or other coverage unit.

(3) Medical or surgical benefits

The term “medical or surgical benefits” means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health or substance use disorder benefits.

(4) Mental health benefits

The term “mental health benefits” means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits

The term “substance use disorder benefits” means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(Added Pub. L. 105-34, title XV, § 1531(a)(4), Aug. 5, 1997, 111 Stat. 1083; amended Pub. L. 107-116, title VII, § 701(c), Jan. 10, 2002, 115 Stat. 2228; Pub. L. 107-147, title VI, § 610(a), Mar. 9, 2002, 116 Stat. 60; Pub. L. 108-311, title III, § 302(a), Oct. 4, 2004, 118 Stat. 1178; Pub. L. 109-151, § 1(c), Dec. 30, 2005, 119 Stat. 2886; Pub. L. 109-432, div. A, title I, § 115(a), Dec. 20, 2006, 120 Stat. 2941; Pub. L. 110-245, title IV, § 401(a), June 17, 2008, 122 Stat. 1649; Pub. L. 110-343, div. C, title V, § 512(c), (g)(3)(A), Oct. 3, 2008, 122 Stat. 3888, 3892.)

AMENDMENTS

2008—Pub. L. 110-343, § 512(g)(3)(A), substituted “Parity in mental health and substance use disorder benefits” for “Parity in the application of certain limits to mental health benefits” in section catchline.

Subsec. (a)(1), (2). Pub. L. 110-343, § 512(c)(7), substituted “mental health or substance use disorder benefits” for “mental health benefits” wherever appearing in pars. (1)(introductory provisions), (A), and (B)(ii) and (2)(introductory provisions), (A), and (B)(ii).

Pub. L. 110-343, § 512(c)(6), substituted “mental health and substance use disorder benefits” for “mental health benefits” wherever appearing in pars. (1)(B)(i) and (C) and (2)(B)(i) and (C).

Subsec. (a)(3) to (5). Pub. L. 110-343, § 512(c)(1), added pars. (3) to (5).

Subsec. (b)(1). Pub. L. 110-343, § 512(c)(7), substituted “mental health or substance use disorder benefits” for “mental health benefits”.

Subsec. (b)(2). Pub. L. 110-343, § 512(c)(2), amended par. (2) generally. Prior to amendment, par. (2) read as follows: “in the case of a group health plan that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).”

Subsec. (c)(1). Pub. L. 110-343, § 512(c)(3)(A), amended par. (1) generally. Prior to amendment, text read as follows: “This section shall not apply to any group health plan for any plan year of a small employer (as defined in section 4980D(d)(2)).”

Subsec. (c)(2). Pub. L. 110-343, § 512(c)(3)(B), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: “This section shall not apply with

respect to a group health plan if the application of this section to such plan results in an increase in the cost under the plan of at least 1 percent.”

Subsec. (e)(3). Pub. L. 110-343, § 512(c)(7), substituted “mental health or substance use disorder benefits” for “mental health benefits”.

Subsec. (e)(4). Pub. L. 110-343, § 512(c)(7), which directed substitution of “mental health or substance use disorder benefits” for “mental health benefits” wherever appearing in this section (other than in any provision amended by section 512(c)(6) of Pub. L. 110-343), was not executed to par. (4) as added by Pub. L. 110-343, § 512(c)(4), to reflect the probable intent of Congress. See below.

Subsec. (e)(4). Pub. L. 110-343, § 512(c)(4), added par. (4) and struck out former par. (4). Prior to amendment, text read as follows: “The term ‘mental health benefits’ means benefits with respect to mental health services, as defined under the terms of the plan, but does not include benefits with respect to treatment of substance abuse or chemical dependency.”

Subsec. (e)(5). Pub. L. 110-343, § 512(c)(4), added par. (5).

Subsec. (f). Pub. L. 110-343, § 512(c)(5), struck out subsec. (f). Text read as follows: “This section shall not apply to benefits for services furnished—

“(1) on or after September 30, 2001, and before January 10, 2002,

“(2) on or after January 1, 2004, and before the date of the enactment of the Working Families Tax Relief Act of 2004,

“(3) on or after January 1, 2008, and before the date of the enactment of the Heroes Earnings Assistance and Relief Tax Act of 2008, and

“(4) after December 31, 2008.”

Subsec. (f)(3), (4). Pub. L. 110-245 added pars. (3) and (4) and struck out former par. (3) which read as follows: “after December 31, 2007.”

2006—Subsec. (f)(3). Pub. L. 109-432 substituted “December 31, 2007” for “December 31, 2006”.

2005—Subsec. (f)(3). Pub. L. 109-151 substituted “December 31, 2006” for “December 31, 2005”.

2004—Subsec. (f)(2), (3). Pub. L. 108-311 added pars. (2) and (3) and struck out former par. (2) which read as follows: “after December 31, 2003.”

2002—Subsec. (f). Pub. L. 107-147 amended heading and text of subsec. (f) generally. Prior to amendment, text read as follows: “This section shall not apply to benefits for services furnished on or after December 31, 2002.”

Subsec. (f). Pub. L. 107-116 substituted “December 31, 2002” for “September 30, 2001”.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110-343 applicable with respect to group health plans for plan years beginning after the date that is 1 year after Oct. 3, 2008, except that amendment by section 512(c)(5) of Pub. L. 110-343 effective Jan. 1, 2009, with special rule for collective bargaining agreements, see section 512(e) of Pub. L. 110-343, set out as a note under section 300gg-26 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108-311, title III, § 302(d), Oct. 4, 2004, 118 Stat. 1179, provided that: “The amendments made by this section [amending this section, section 1185a of Title 29, Labor, and section 300gg-5 of Title 42, The Public Health and Welfare] shall take effect on the date of the enactment of this Act [Oct. 4, 2004].”

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107-147, title VI, § 610(b), Mar. 9, 2002, 116 Stat. 60, provided that: “The amendment made by subsection (a) [amending this section] shall apply to plan years beginning after December 31, 2000.”

§ 9813. Coverage of dependent students on medically necessary leave of absence

(a) Medically necessary leave of absence

In this section, the term “medically necessary leave of absence” means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that—

- (1) commences while such child is suffering from a serious illness or injury;
- (2) is medically necessary; and
- (3) causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

(b) Requirement to continue coverage

(1) In general

In the case of a dependent child described in paragraph (2), a group health plan shall not terminate coverage of such child under such plan due to a medically necessary leave of absence before the date that is the earlier of—

- (A) the date that is 1 year after the first day of the medically necessary leave of absence; or
- (B) the date on which such coverage would otherwise terminate under the terms of the plan.

(2) Dependent child described

A dependent child described in this paragraph is, with respect to a group health plan, a beneficiary under the plan who—

- (A) is a dependent child, under the terms of the plan, of a participant or beneficiary under the plan; and
- (B) was enrolled in the plan, on the basis of being a student at a postsecondary educational institution (as described in subsection (a)), immediately before the first day of the medically necessary leave of absence involved.

(3) Certification by physician

Paragraph (1) shall apply to a group health plan only if the plan, or the issuer of health insurance coverage offered in connection with the plan, has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

(c) Notice

A group health plan shall include, with any notice regarding a requirement for certification of student status for coverage under the plan, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

(d) No change in benefits

A dependent child whose benefits are continued under this section shall be entitled to the

same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(e) Continued application in case of changed coverage

If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(Added Pub. L. 110-381, §2(c)(1), Oct. 9, 2008, 122 Stat. 4084.)

REFERENCES IN TEXT

Section 102 of the Higher Education Act of 1965, referred to in subsec. (a), is classified to section 1002 of Title 20, Education.

EFFECTIVE DATE

Pub. L. 110-381, §2(d), Oct. 9, 2008, 122 Stat. 4086, provided that: “The amendments made by this Act [enacting this section, section 1185c of Title 29, Labor, and sections 300gg-7 and 300gg-54 of Title 42, The Public Health and Welfare] shall apply with respect to plan years beginning on or after the date that is one year after the date of the enactment of this Act [Oct. 9, 2008] and to medically necessary leaves of absence beginning during such plan years.”

§ 9815.¹ Additional market reforms

(a) General rule

Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and

(2) to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) Exception

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the

¹ So in original. No section 9814 has been enacted.

Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(Added Pub. L. 111-148, title I, §1563(f), formerly §1562(f), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 270, 911.)

REFERENCES IN TEXT

The Public Health Service Act, referred to in text, is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of title XXVII of the Act is classified generally to part A (§300gg et seq.) of subchapter XXV of chapter 6A of Title 42, The Public Health and Welfare. Sections 2716 and 2718 of title XXVII of the Act are classified to sections 300gg-16 and 300gg-18, respectively, of Title 42. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this Title 42 and Tables.

The Patient Protection and Affordable Care Act, referred to in text, is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of Title 42, The Public Health and Welfare, and Tables.

Subchapter C—General Provisions

Sec.	
9831.	General exceptions.
9832.	Definitions.
9833.	Regulations.
9834.	Enforcement.

AMENDMENTS

2008—Pub. L. 110-233, title I, §103(e)(2), May 21, 2008, 122 Stat. 899, added item 9834.

1997—Pub. L. 105-34, title XV, §1531(a)(3), Aug. 5, 1997, 111 Stat. 1081, added subchapter heading and analysis.

§ 9831. General exceptions

(a) Exception for certain plans

The requirements of this chapter shall not apply to—

- (1) any governmental plan, and
- (2) any group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) Exception for certain benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(1).

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(2) if the benefits—

- (A) are provided under a separate policy, certificate, or contract of insurance; or
- (B) are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in

section 9832(c)(3) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) Supplemental excepted benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(Added Pub. L. 104-191, title IV, §401(a), Aug. 21, 1996, 110 Stat. 2080, §9804; renumbered §9831 and amended Pub. L. 105-34, title XV, §1531(a)(2), (b)(1)(B)–(E), Aug. 5, 1997, 111 Stat. 1081, 1084, 1085.)

AMENDMENTS

1997—Pub. L. 105-34 renumbered section 9804 of this title as this section and substituted reference to section 9832 of this title for reference to section 9805 of this title in subssecs. (b) and (c)(1) to (3).

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105-34 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 1531(c) of Pub. L. 105-34, set out as a note under section 4980D of this title.

§ 9832. Definitions

(a) Group health plan

For purposes of this chapter, the term “group health plan” has the meaning given to such term by section 5000(b)(1).

(b) Definitions relating to health insurance

For purposes of this chapter—

(1) Health insurance coverage

(A) In general

Except as provided in subparagraph (B), the term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(B) No application to certain excepted benefits

In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

(2) Health insurance issuer

The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health

maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). Such term does not include a group health plan.

(3) Health maintenance organization

The term “health maintenance organization” means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(c) Excepted benefits

For purposes of this chapter, the term “excepted benefits” means benefits under one or more (or any combination thereof) of the following:

(1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers’ compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental

coverage provided to coverage under a group health plan.

(d) Other definitions

For purposes of this chapter—

(1) COBRA continuation provision

The term “COBRA continuation provision” means any of the following:

(A) Section 4980B, other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609 of such Act.

(C) Title XXII of the Public Health Service Act.

(2) Governmental plan

The term “governmental plan” has the meaning given such term by section 414(d).

(3) Medical care

The term “medical care” has the meaning given such term by section 213(d) determined without regard to—

(A) paragraph (1)(C) thereof, and

(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.

(4) Network plan

The term “network plan” means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(5) Placed for adoption defined

The term “placement”, or being “placed”, for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement with such person terminates upon the termination of such legal obligation.

(6) Family member

The term “family member” means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 9801(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(7) Genetic information

(A) In general

The term “genetic information” means, with respect to any individual, information about—

(i) such individual’s genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) Inclusion of genetic services and participation in genetic research

Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) Exclusions

The term “genetic information” shall not include information about the sex or age of any individual.

(8) Genetic test

(A) In general

The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) Exceptions

The term “genetic test” does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(9) Genetic services

The term “genetic services” means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(10) Underwriting purposes

The term “underwriting purposes” means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2080, § 9805; renumbered § 9832, Pub. L. 105-34, title XV, § 1531(a)(2), Aug. 5, 1997, 111 Stat. 1081; amended Pub. L. 110-233, title I, § 103(d), May 21, 2008, 122 Stat. 898.)

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in subsecs. (b)(2) and (d)(1)(B), is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 832, as amended. Section 514(b)(2) of the Act is classified to section 1144(b)(2) of

Title 29, Labor. Section 609 of the Act is classified to section 1169 of Title 29. Part 6 of subtitle B of title I of the Act is classified generally to part 6 (§1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The date of the enactment of this section, referred to in subsec. (b)(2), is the date of enactment of Pub. L. 104-191, which was approved Aug. 21, 1996.

Section 1882(g)(1) of the Social Security Act, referred to in subsec. (c)(4), is classified to section 1395ss(g)(1) of Title 42, The Public Health and Welfare.

The Public Health Service Act, referred to in subsec. (d)(1)(C), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Title XXII of the Act is classified generally to subchapter XX (§300bb-1 et seq.) of chapter 6A of Title 42. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

AMENDMENTS

2008—Subsec. (d)(6) to (10). Pub. L. 110-233 added pars. (6) to (10).

1997—Pub. L. 105-34 renumbered section 9805 of this title as this section.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110-233 applicable with respect to group health plans for plan years beginning after the date that is one year after May 21, 2008, see section 103(f)(2) of Pub. L. 110-233, set out as a note under section 9802 of this title.

§ 9833. Regulations

The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this chapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this chapter.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2082; § 9806; renumbered § 9833, Pub. L. 105-34, title XV, § 1531(a)(2), Aug. 5, 1997, 111 Stat. 1081.)

REFERENCES IN TEXT

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in text, is section 104 of Pub. L. 104-191, which is set out as a note under section 300gg-92 of Title 42, The Public Health and Welfare.

AMENDMENTS

1997—Pub. L. 105-34 renumbered section 9806 of this title as this section.

§ 9834. Enforcement

For the imposition of tax on any failure of a group health plan to meet the requirements of this chapter, see section 4980D.

(Added Pub. L. 110-233, title I, § 103(e)(1), May 21, 2008, 122 Stat. 899.)

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after the date that is one year after May 21, 2008, see section 103(f)(2) of Pub. L. 110-233, set out as an Effective Date of 2008 Amendment note under section 9802 of this title.